STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1912

February 8, 1982

To: All County Welfare Directors

Letter No. 82-6

QUARTERLY SHARE OF COST (SOC)

This letter transmits the answers to the questions raised during the recent regional county training sessions. The questions and answers appear in Attachment I grouped by subject matter. If during your implementation new questions arise, please direct them to your Medi-Cal program consultant. If a sufficient number of questions of general applicability are received, another question and answer letter will be generated.

The State Printing Plant is experiencing some problems which may affect delivery of the revised Quarterly SOC forms. However, the initial supply of form MC 177S will be four part with blue carbon interleaf. Part one and two will be white paper, part three will be yellow and part four will be gold. This will only affect the initial supply and then we will return to the four part pink NCR paper. We expect all of the revised Quarterly SOC forms to be delivered to our warehouse by February 5, 1982. In order to speed up the delivery process please submit your forms request order (on the standard form) to the following address instead of the warehouse.

Department of Health Services
Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814
Attention: David Markell

If you have any questions contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachment
cc: Medi-Cal Liaisons
Medi-Cal Program Consultant

Expiration Date: July 30, 1982

A. Eligibility Questions

Intercounty Transfers (ICTs)

1. Question: When does the resonsibility shift from the initiating county to the new county for multi-month share-of-cost (SOC) cases?

   Answer: The shift in responsibility should coincide with the SOC period; however, the new county of responsibility shall be given a minimum of 60 days in which to prepare for acceptance of the transfer.

   Example: The SOC period established by County A is June-August. On July 15, County A initiates an ICT to County B. This case would remain the responsibility of County A through November, month of eligibility, unless County B agrees to accept responsibility effective September 1.

   A post hearing change will be made to Section 50137 to more clearly state this policy.

Projection of Anticipated Income

2. Question: If a person will be starting a new job during an SOC period, how is staff to project mandatory deductions?

   Answer: If the Medi-Cal regulations changing earned income deductions to standard amounts have not been filed by the time quarterly SOC is implemented, these are the guidelines that should be followed:

   a. Obtain as much information from the applicant as possible (e.g., are there mandatory union dues, health insurance premimums, amounts for meals withheld, retirement withholdings, number of dependents claimed for tax purposes, etc.?) The applicant may have to contact the future employer for some of this information.

   b. Assume that State Disability Insurance (SDI) will be withheld unless you have information to the contrary. This deduction is always one percent of the gross pay.

   c. Assume that Social Security Tax (Federal Insurance Contribution Act (FICA) or Old Age Survivors and Disability Insurance (OASDI)) will be withheld unless you have information to the contrary. Effective January 1, 1982, this deduction will be 6.7 percent of the gross pay.

For federal and state income tax withholding amounts, you can obtain copies of employer tax guides from IRS and Franchise Tax Board. (Probably one per office, kept in a central location, would be sufficient.) Based upon the number of dependents claimed and whether or not the individual meets the definition of head of household, the appropriate withholding amounts can be estimated.

If you believe an approach different from above would produce equally reliable results and would be more efficient, please submit your plan to us for approval. Any approved alternative will be shared with all county departments and state quality control staff.

SOC Periods

3. Some of the illustrations for determining SOC periods are included as Attachments II and III.

4. Question: Can the State consider simplifying the quarterly SOC concept by defining quarters as calendar quarters rather than using the month of application as the defining point?

   Answer: This option was considered, however, based upon the federal regulations and written communications from federal staff, such a definition would result in a federal compliance issue. Even given the "flexibility changes" contained in PL 97-35, the Medicaid regulations require that states have a prospective budgeting system. Additionally, we have recently received correspondence indicating that, for retroactive eligibility determinations, states must consider the income in the three months prior to application in the SOC determination.

5. Question: The MFBU consists of an ABD-MN person and an MI spouse with a quarterly SOC period of June-August. The ABD-MN person enters LTC July 2 and returns to the home September 3. What are the share of cost periods?

   Answer: Based upon input from county staff after the training a policy change has been made in this area. The change is that the spouse at home will keep the originally established three-month period when the other spouse enters/leaves LTC. (Examples have already been distributed to the Medi-Cal Liaison in your county). This same policy applies when there are children in the home.

In the example above the SOC periods would be as follows:

June-August (ABD-MN/MI June and July; MI only August).

August (ABD-MN).

September-November (ABD-MN/MI September-November)

Note the ABD-MN should not be added until October if the action is adverse. In most instances the action will not be adverse. (See Question 11).

SOC Adjustments Due to Decreases in SOC

6. Question: If a person whose ongoing SOC is now zero due to an SOC adjustment, can the amount to be adjusted be "saved" and applied the next time changes in circumstances result in an SOC?

   Answer: Yes. Regulations require that for persons who elect to have an overcharge adjusted in future periods, that the adjustment take place as soon as possible. Thus, if a person goes from an SOC to a lower SOC, the adjustment must begin immediately. If the person goes from an SOC to no SOC and still elects the adjustment method, the adjustment must be made as soon as the person again has an SOC.

Increase in SOC

7. Question: If an SOC increases during a multi-month SOC period, can MFBU meet the lower SOC and be certified for the month(s) in the period which are prior to the effective date of the change?

   Answer: Yes, provided the lower SOC is met with medical expenses incurred prior to the effective date of the increase.

   Example: A family is determined eligible with a $50 SOC for May-July. On May 28, the family reports that an increase in income will occur in June. A Notice of Action is sent indicating that due to the increase in income which will be counted effective July 1 (because of ten-day notice requirements the increase cannot be reflected for the month of June), the SOC for the May-July quarter will be $110. A new MC 177S is included with the Notice. On June 20, the original MC 177S is brought into the office. The family met the $50 SOC on June 17. Since technically the increase for the May-July period is not effective until July 1, the family is entitled to cards for May and June after having obligated $50. The MC 177S should be sent to Benefits Review Unit (BRU) with only the first two eligibility boxes checked. A supplemental MC 177S should be issued for July with a $60 supplemental SOC amount ($110-$50).

Adding Persons to the MFBU

8. Question: How is a case processed when the inclusion of an excluded family member will increase the multi-month SOC after the MFBU has already met the SOC and received Medi-Cal cards?

   Answer: Attachment IV outlines various case situations for a family with a $90 multi-month SOC. The excluded son, when added to the MFBU, increases the multi-month SOC by $10 each month. The increase is immediately computed since the inclusion of an excluded family member is not an adverse action per Section 50015.

   Example 1 shows the MC 176M and MC 177S when the son is excluded from the MFBU.

   Example 2 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A and B, and the son is to be included in the MFBU for months B and C.

   Note: Only the son is listed as elgibile on the MC 177S for month B since the rest of the MFBU has met the SOC and received Medi-Cal cards. Everybody is listed as eligible on the MC 177S for month C since no one has received a Medi-Cal card.

   Example 3 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A, B, and C, and the son is to be included in the MFBU for month C only.

   Example 4 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A, B, and C, and the son is to be included in the MFBU for month C and also receive retroactive eligibility for months A and B, and month C of the prior multi-month period for the MFBU. The MFBU has already met the SOC and received Medi-Cal cards for the prior multi-month period.

   Note: The son has a one-month SOC for month C of the prior multi-month SOC period. His income for months A and B of the prior period are not to be counted because he was not a member of the MFBU, and therefore, the entire multi-month period need not be reactivated in computing his SOC.

9. Question: When a family member, not currently on Medi-Cal, returns to the home, is that person's eligibility initially determined separately?

Answer: The evaluation of eligibility of such persons under a multi-month SOC system is the same as under the current monthly SOC system; that is, eligibility is evaluated both in terms of the individual and in terms of the impact upon the MFBU members. If either the individual does not meet the eligibility requirements or inclusion of the individual in the MFBU renders the entire unit ineligible, the individual is not added to the MFBU during the month of return.

Example: On March 8, it is reported that the absent parent returned to the home on February 27. When combining his/her property with the property of the MFBU, the entire family becomes ineligible. In this instance, the absent parent would not be added to the MFBU for March and the remaining family members would be terminated effective March 31, providing the property is not spent down.

There are instances in which the person returning to the home can establish separate eligibility during the month of return. For example, a 20-year-old who has been living independently is hospitalized and moves back with his/her parents to recuperate on May 18, giving up his/her former apartment. For the month of May, the 20-year-old can apply on his/her own because he/she was not living with the parents for part of the month. Beginning June 1, eligibility would be established in the parents' MFBU.

Adverse Actions

10. Question: Why is the addition of a voluntarily excluded child to the MFBU treated differently from the addition of a family member with income who has returned to the home; that is, the income of the formerly excluded child is considered in the SOC computation beginning with the month in which the child is placed in the MFBU, whereas the income of a person returning to the home is considered beginning with the first of the month following issuance of a ten-day notice if there will be an increased SOC even though the person is added to the MFBU immediately?

Answer: The reason for the difference stems from the current definition of adverse action. An increase in the SOC due to the inclusion of a voluntarily excluded person is defined as not being an adverse action. We are in the process of amending the definition of adverse action so that an increase in the SOC due to the addition of any family member to the MFBU is not an adverse action. Until this nonemergency regulation revision is filed, however, a ten-day notice must be given before increasing the SOC of the MFBU when a family member returns to the home.

11. Question: How do you determine whether a change in the SOC is an adverse action when you are combining two MFBUs into one?

Example: Mr. ABD-MN is in LTC with a monthly SOC of $474 and his MI spouse at home has a zero quarterly SOC. Mr. returns to the home and the couple will have a $198 quarterly SOC. Is this an adverse action for the MI spouse?

Answer: If the new SOC amount is equal to or less than the two SOCs combined, then the action is not adverse and a ten-day notice is not required. Thus, in the example above, the $198 SOC is not an adverse action.

Implementation

12. Question: When quarterly SOC is implemented, how far back in time is it applicable?

Answer: The regulations became effective November 30, 1981; therefore, the multi-month SOC concept should be applied to December 1981 and forward months for which eligibility is being determined at time of implementation.

B. Procedural Questions

1. Question: When something like the aid code changes during the quarter, where is it shown on the MC 176 and MC 177?

Answer: There is space on the back of the MC 176 to notate changes occurring during the quarter. A note clearly explaining the change and the effective date should be attached to the MC 177 before submission to BRU.

2. Question: Do you list just the beginning month of eligibility for the SOC period at the top of the MC 176 or all of the months for the SOC period?

Answer: All months of the SOC period should be listed. This was inadvertently not done on the MC 176 examples distributed during training.

3. Question: Will BRU mail the BRU generated cards to the paper counties the way CID does?

Answer: No. BRU will mail the cards to the beneficiaries. Paper counties should follow the code-a-phone procedures for reporting changes to BRU.

4. Question: Will the MC 210 income section be revised to show three months of income information?

   Answer: Yes; however, until the revision occurs, the county may choose to substitute the three-month quarterly status report form when obtaining income information at time of application.

5. Question: May the county still choose to send out Medi-Cal status reports on a monthly basis?

   Answer: Yes.

6. Question: Can the county send changes to BRU in writing rather than use the code-a-phone procedures if changes are known in advance of card issuance by BRU?

   Answer: No. All changes must be reported to BRU via the code-a-phone.

BEGINNING DATE SDC PERIOD

1. MO. OF APP
APP/ELIG
APRIL MAY JUNE JULY AUG. SEPT

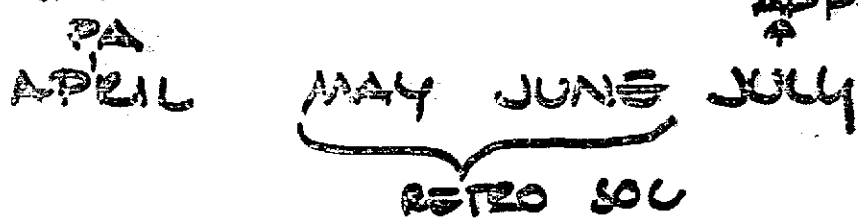
2. MO OF ELIG.
APP ELIG.
APRIL MAY JUNE JULY AUG. SEPT. OCT.

3 RESTORATIONS
a. DISC. APP
APRIL MAY JUNE JULY AUG. SEPT.

b. DISC APP
APRIL MAY JUNE JULY AUG. SEPT

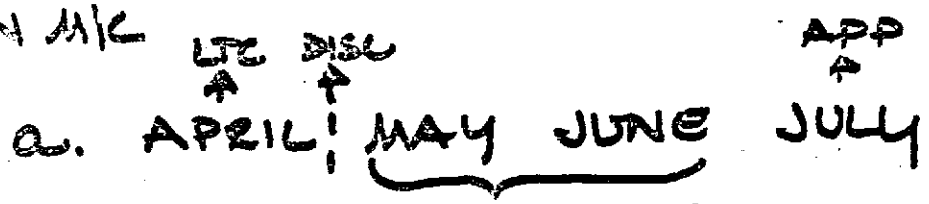
RETRO

1. ON P.A.

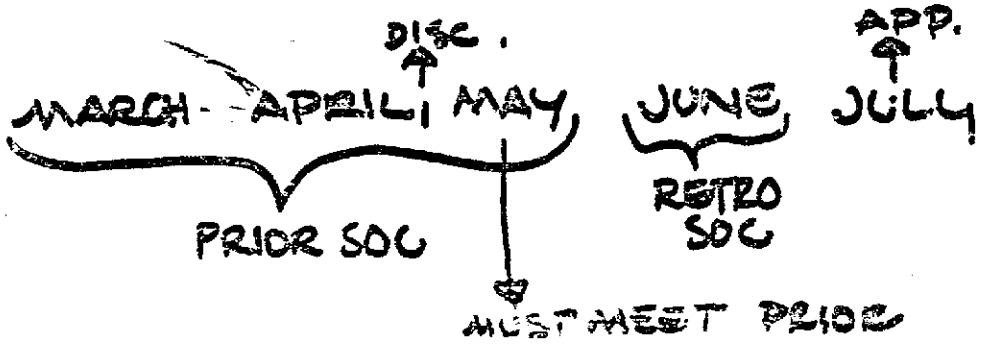


2. ON M/C

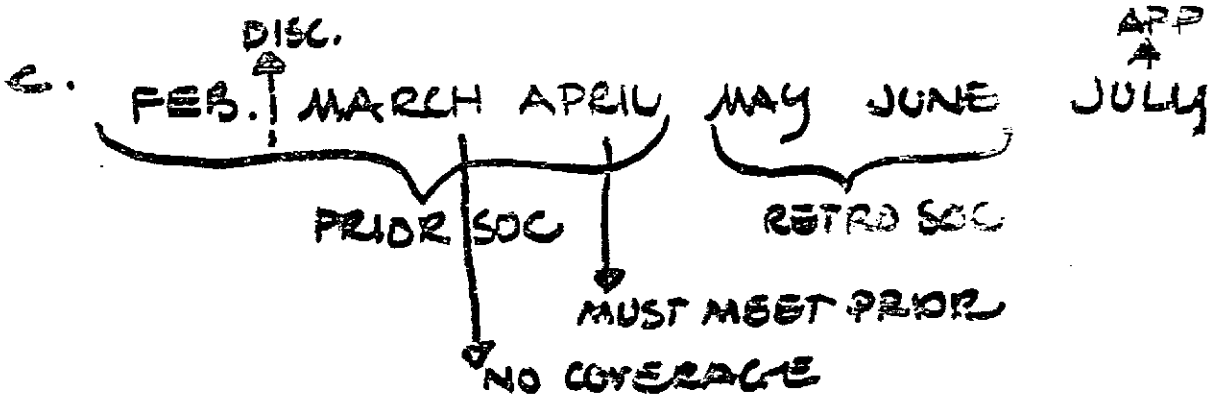
a.



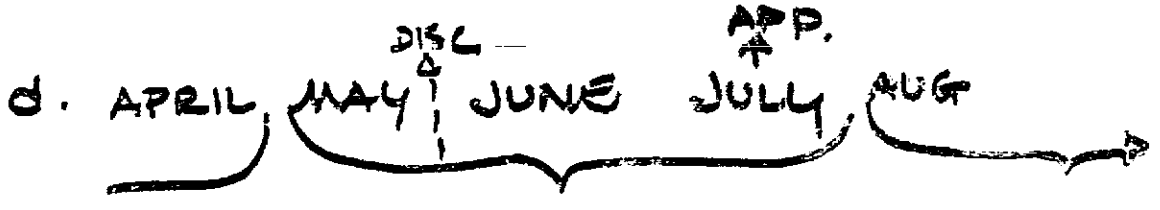
b.



c.

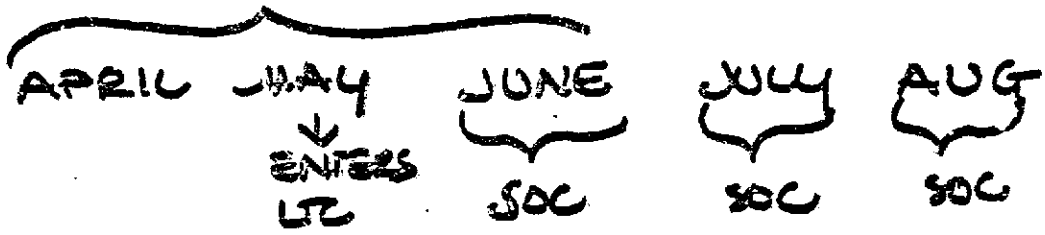


d.

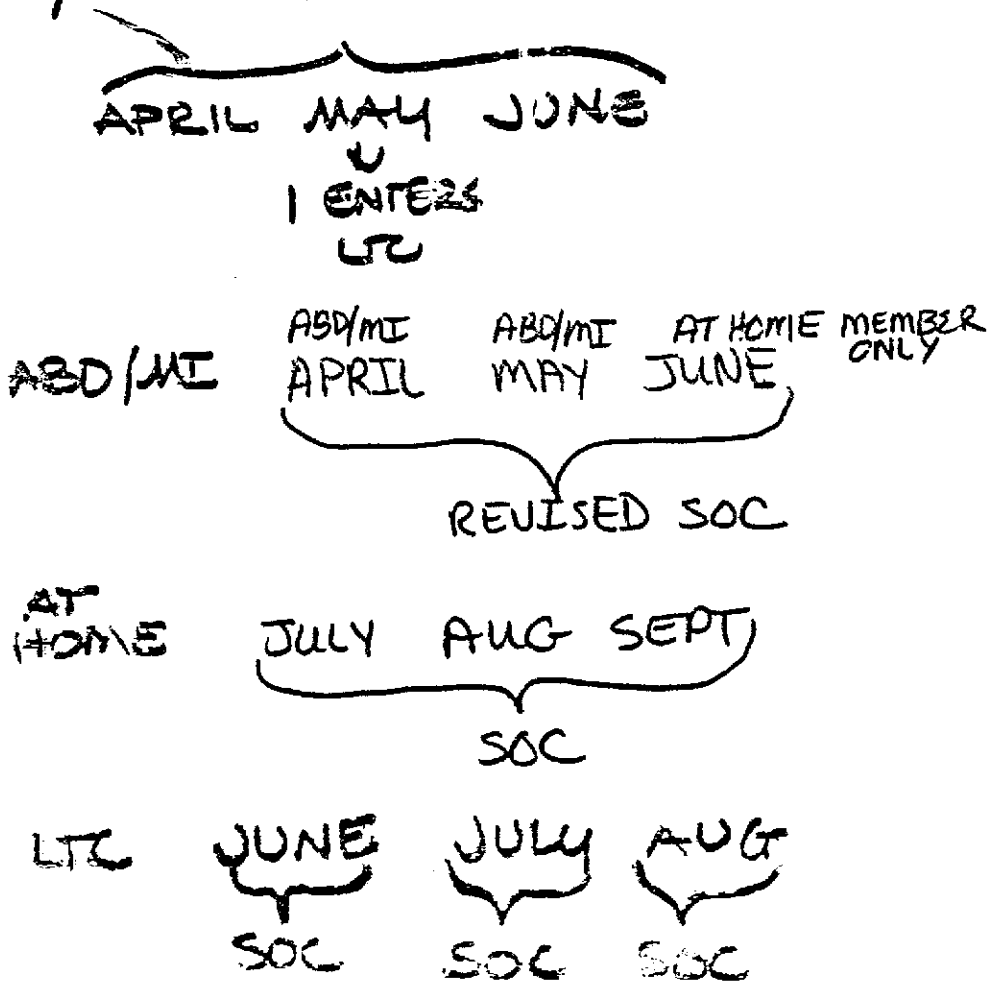


LTC

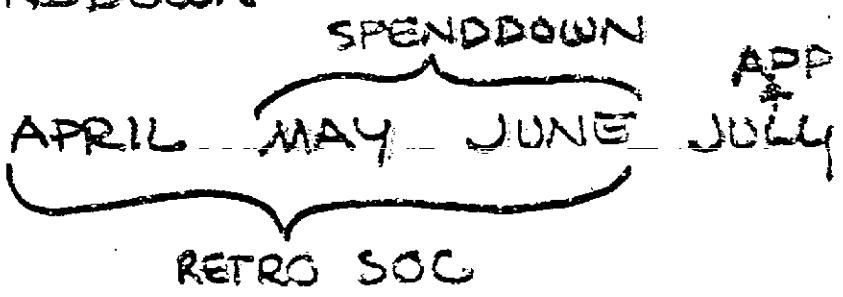
1. ABD COUPLE



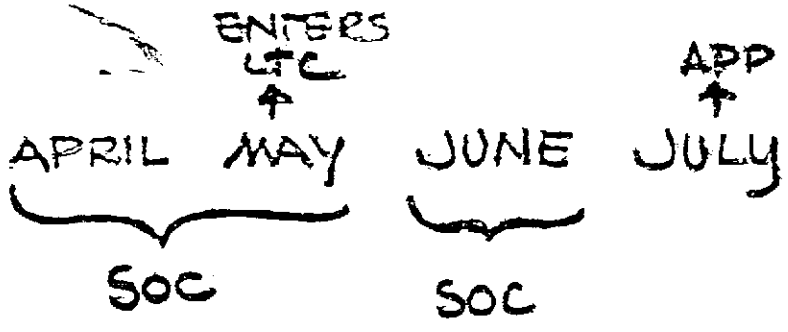
2. MI / ABD COUPLE



5. SPENDDOWN

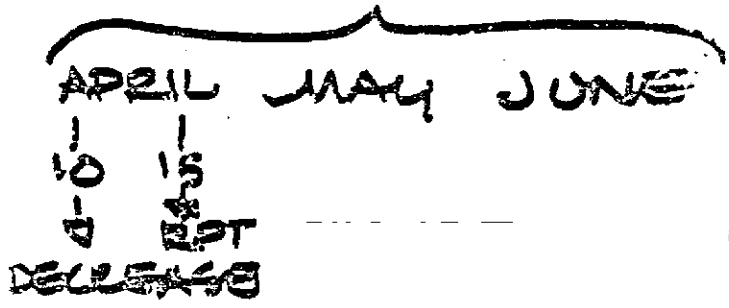


4. LTC



DECREASES IN SOC

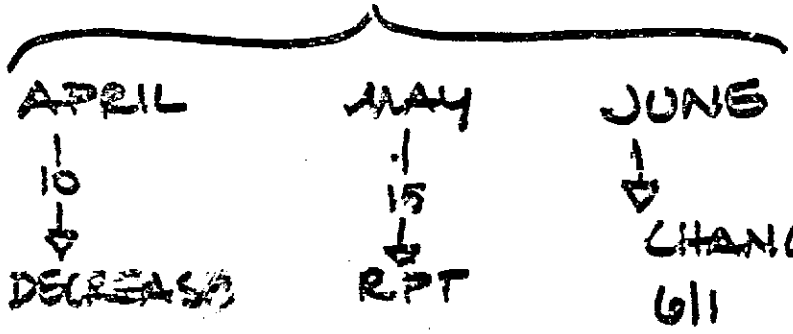
1. CHANGE REPORTED TIMELY



CHANGE EFFECTIVE ALL 3 MO

EX
NST INC.
$675 TO 575
NEED $475
SOC $600 TO $300

2. CHANGE NOT RPT. TIMELY



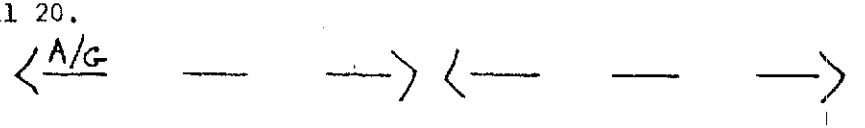
Ex. SOC $600 TO $500

Attachment II-6

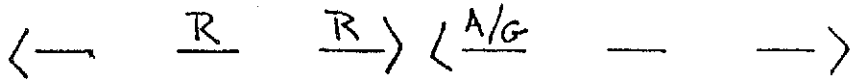
<> = original SSC period
( ) = revised SSC period

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

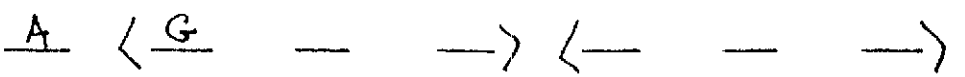
1. Applies April 15; granted April 20.



2. Applies April 15, requests retro for Feb. & Mar.; granted April 20.



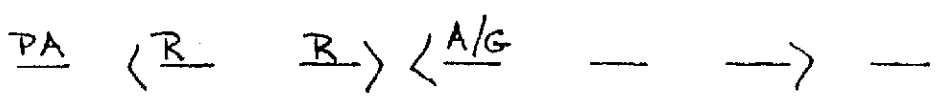
3. Applies April 15; over property for April, but within property as of May 1; granted May 2.



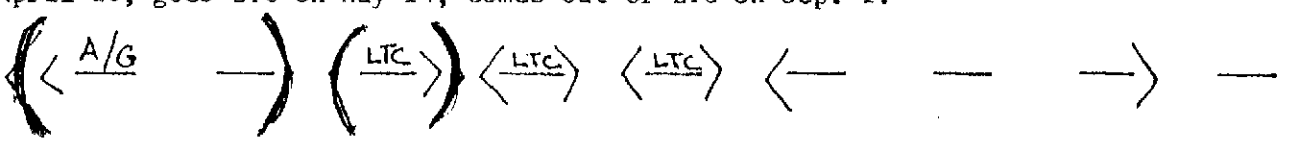
4. Applies April 15; requests retro for Mar.; over property for April, but within property for Mar. & May; granted May 2.

5. Applies April 15; granted April 20; goes LTC on Aug 13.

6. Applies April 15; requests retro for Feb. & Mar.; AFDC eligible for Jan.; granted April 20.



7. Applies April 15; granted April 20; goes LTC on May 14; comes out of LTC on Sep. 2.



JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

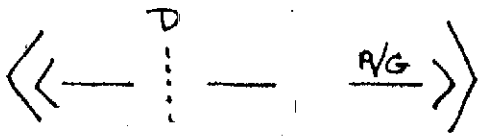
Attachment II - 7

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

8. Applies April 15; requests retro for Jan., Feb. & Mar.; went into LTC on Feb. 14; granted April 20.

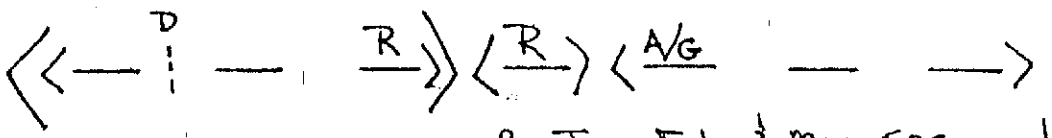
for Jan., Feb. & Mar. SOC quarter

9. Requests discontinuance on January 10 (effective February 1); reapplies March 10; granted March 17.



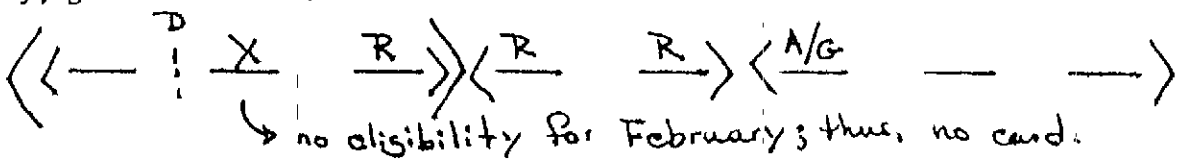
for Jan., Feb. & Mar. SOC quarter

10. Requests discontinuance on Jan. 10 (effective Feb. 1); reapplies May 14; requests retro for Mar. & Apr.; granted May 21.



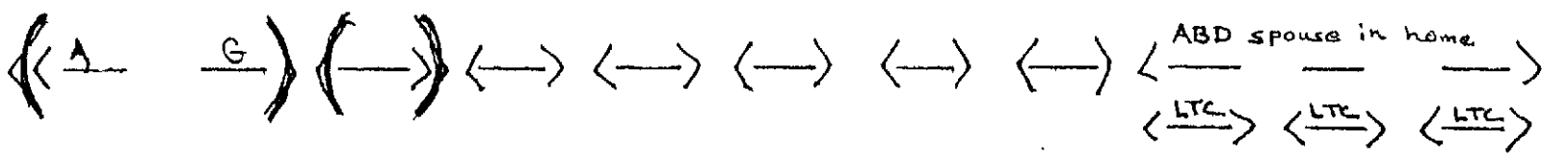
for Jan., Feb. & Mar. SOC quarter

11. Requests discontinuance on Jan. 10 (effective Feb. 1); reapplies June 21; requests retro for Mar., Apr. & May; granted June 28.

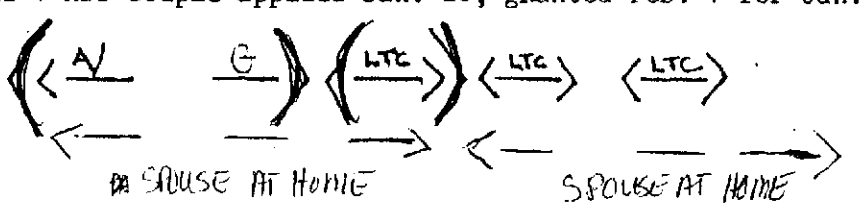


↳ no eligibility for February; thus, no card.

12. ABD couple applies Jan 20; granted Feb. 7 for Jan.; one enters LTC on Feb. 10.



13. MI + ABD couple applies Jan. 20; granted Feb. 7 for Jan.; ABD enters LTC on Feb. 10.



JAN FEB MAR APR MAY JU JUL AUG SEP OCT NOV DEC

State of California—Health and Welfare Agency

SHARE OF COST DETERMINATION — MFBUs WHICH DO NOT INCLUDE LTC PERSONS Attachment III - 1

Case Name: EXAMPLE 1 | County District | County Use

☐ New Application ☐ Redetermination ☐ Change ☐ Retroactive Elig. ☐ Correction

Effective Eligibility Date for this Budget: Mo. Apr-May-Jun Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name — First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
9	85	0123456	0	01	Larry Larrence	9 14 38	m	(1) 512-34-5678 (2)	Y
9	85	0123456	0	02	Mary Larrence	6 20 39	F	(1) 512-98-7654 (2)	Y
9	83	0123456	0	10	Janet Larrence	5 14 69	F	(1) 522-34-5678 (2)	Y
		Excluded			John Larrence	7 7 63	m	(1) 321-98-7654 (2)	Y
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. Income of MFBU members applying as ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any Income deduction	−$20		−$20		−$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net Income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)	0 →		

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned Income	900 →		
9a. If CG in last 4 mos. enter $30			
9b. 1/3 remainder			
10. mandatory	200		
11. Work Related	75		
12. Total deduct. (add 9, 10, & 11)	275		
13. Countable earned Income	625 →		

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Mo
14. Subtotal (add 7 and 13)	625 →		
15. Child support/ alimony			
16. Total countable Income (14 minus 15)	625 →		

MC 176M (9/81)

Attachment III-2

Case Name:

	Month 1	Month 2	Month 3
1. Countable income from I 18			
2. Countable income from II 16	625	→	→
3. Inc. allocated from LTC/B&C person to family members at home (176W, Part IV)			
4. Combined countable income (add 1, 2, and 3)	625	→	→
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)	-0-		
6. Special deduction (176W, Part II)	-0-		
7. Income to determine PA Eligibility	-0-		
8. Health Insurance	12.50	→	→
9.			
10.			
11. Total allocations/deductions (add 5 through 10)	12.50	→	→
12. Total net nonexempt income (4 minus 11)	612.50	→	→
13. Total net nonexempt income rounded	613	613	613
14. Maintenance need	583	583	583

SHARE OF COST

13a. Total of Mos 1, 2, and 3	1839
14a. Total of Mos. 1, 2, and 3	1749
15. Share of cost (13a. minus 14a.)	90
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

Eligibility Worker Signature	Worker Number	Computation Date	County Use

EXAMPLE 1 ATTACHMENT III 3

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Se

CO DIST	COUNTY U
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.			Share of Cost	Page
Month A	Month B	Month C	The amount that you must pay or obligate is:	Re:
Apr 82	May 82	Jun 82	$ 90 00	No
Mo. Yr.	Mo. yr.	Mo. Yr.		(Yes/N

Name

Address

City/State/Zip

County Code
49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number				Name – Last, First	Eligible In			Birthdate			Sex	Other Cov. Code	Social Security No.	HIC or RR No.
Aid	7 Digit Serial No.	FBU	Pers.		A	B	C	Mo.	Day	Yr.				
85	0123456	0	01	Larrence, Larry	X	X	X	9	14	38	M	Y	512345678	
85	0123456	0	02	Larrence, Mary	X	X	X	6	20	39	F	Y	512987654	
85	0123456	0	10	Larrence, Janet	X	X	X	5	14	69	F	Y	522345678	
83	0123456	0	10	Larrence, John				7	7	63	M	Y	521987654	
	Excluded													

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare th
payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal p
that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the pa
This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi- $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By:	Trans.	Replace
Date of Certification					

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th
amounts listed above in the "Billed Patient" column.

X SIGNATURE OF APPLICANT DATE

State of California - Health and Welfare Agency

SHARE OF COST DETERMINATION — MFBUs WHICH DO NOT INCLUDE LTC PERSONS Attachment III - 4

Case Name	County District	County Use
EXAMPLE 2		

☐ New Application ☐ Redetermination ☒ Change ☐ Retroactive Elig. ☐ Correction

Effective Eligibility Date for this Budget: Mo. May - Jun Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name — First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
								(1) (2)	
								(1) (2)	
								(1) (2)	
19	83	0123456	0	11	John Lawrence	7 7 63	M	(1) 521.98.765.4. (2)	Y
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. Income of MFBU members applying as ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income deduction	−$20		−$20		−$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net Income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)		0	

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned income		1100	
9a. If CG in last 4 mos, enter $30			
9b. 1/3 remainder			
10. mandatory		250	
11. Work Relat.		106	
12. Total deduct. (add 9, 10, & 11)		356	
13. Countable earned income		744	

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
14. Subtotal (add 7 and 13)		744	
15. Child support/ alimony			
16. Total countable income (14 minus 15)		744	

Case Name:

	Month 1	Month 2	Month 3
1. Countable income from I 18			
2. Countable income from II 16		744	→
3. Inc. allocated from LTC/B&C person to family members at home (176W, Part IV)			
4. Combined countable income (add 1, 2, and 3)		744	→
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)			
6. Special deduction (176W, Part II)			
7. Income to determine PA Eligibility			
8. Health Insurance		12.50	→
9.		~~12.50~~	→
10.			
11. Total allocations/deductions (add 5 through 10)		12.50	→
12. Total net nonexempt income (4 minus 11)		731.50	→
13. Total net nonexempt income rounded	613	732	732
14. Maintenance need	583	692	692

SHARE OF COST	
13a. Total of Mos 1, 2, and 3	2077
14a. Total of Mos. 1, 2, and 3	1967
15. Share of cost (13a. minus 14a.)	110
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

5/12/82 mother requested that son John be included in the MFBU for May and ongoing. John was previously excluded

Eligibility Worker Signature	Worker Number	Computation Date	County Use

ATTACHMENT III-6

State of California—Health and Welfare Agency
Medi-Cal Program

EXAMPLE 2

Department of Health Sv

CO DIST	COUNTY U
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.			Share of Cost	Page
Month A	Month B	Month C	The amount that you must pay or obligate is:	Re.
Mo. Yr.	May 82 Mo. yr.	Jun 82 Mo. Yr.	$ 20.00	No (Yes/N

Name

Address

City/State/Zip

County Code: 49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number				Name — Last, First	Eligible In			Birthdate			Sex	Other Cov. Code	Social Security No.	HIC or RR No.
Aid	7 Digit Serial No.	FBU	Pers.		A	B	C	Mo.	Day	Yr.				
85	0123456	0	01	Larrence, Larry			X	9	14	38	m	Y	512 34 5678	
85	0123456	0	02	Larrence, Mary			X	6	20	39	F	Y	512 98 7654	
83	0123456	0	10	Larrence, Janet			X	5	14	69	F	Y	522 34 5678	
83	0123456	0	11	Larrence, John		X	X	7	7	63	m	Y	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare tha
payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal progra
that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the pa
This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi- $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By:	Trans.	Replace
Date of Certification					

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th
amounts listed above in the "Billed Patient" column.

X SIGNATURE OF APPLICANT DATE

SHARE OF COST DETERMINATION – MFBUs WHICH DO NOT INCLUDE LTC PERSONS Attachment III - 7

Case Name: EXAMPLE 3 | County District | County Use

☐ New Application ☐ Redetermination ☑ Change ☐ Retroactive Elig. ☐ Correction

Effective Eligibility Date for this Budget: Mo. JUNE Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name – First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverag
								(1) (2)	
								(1) (2)	
								(1) (2)	
9	83	0123456	0	11	John Larrence	7 7 63		(1) 521.98.7654 (2)	Y
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. Income of MFBU members applying as ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income deduction	–$20		–$20		–$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net Income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)			

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned income			110
9a. If CG in last 4 mos, enter $30			
9b. 1/3 remainder			
10. Mandatory			25
11. Work Rel			10
12. Total deduct. (add 9, 10, & 11)			35
13. Countable earned income			74

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Mo
14. Subtotal (add 7 and 13)			74
15. Child support/ alimony			
16. Total countable income (14 minus 15)			74

MC 176M (9/81)

Attachment 11-3

Case Name:

	Month 1	Month 2	Month 3
1. Countable Income from I 18			
2. Countable Income from II 16			744
3. Inc. allocated from LTC/B&C person to family members at home (176W, Part IV)			
4. Combined countable income (add 1, 2, and 3)			744
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)			
6. Special deduction (176W, Part II)			
7. Income to determine PA Eligibility			
8. Health Insurance			12.50
9.			
10.			
11. Total allocations/deductions (add 5 through 10)			12.50
12. Total net nonexempt income (4 minus 11)			731.50
13. Total net nonexempt income rounded	613	613	732
14. Maintenance need	583	583	692

SHARE OF COST

13a. Total of Mos 1, 2, and 3	1958
14a. Total of Mos. 1, 2, and 3	1858
15. Share of cost (13a. minus 14a.)	100
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

6/14/82 mother phoned and requested Medi-Cal for John effective 6/1/82. John was previously excluded due to income.

Eligibility Worker Signature	Worker Number	Computation Date	County Use

Attachment III-9

EXAMPLE 3

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Se

CO DIST	COUNTY U
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.			Share of Cost	Page
Month A	Month B	Month C	The amount that you must pay or obligate is:	Retro
Mo. Yr.	Mo. yr.	JUN 82 Mo. Yr.	$ 10 00	No (Yes/N

Name

Address

City/State/Zip

County Code
49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number				Name – Last, First	Eligible In			Birthdate			Sex	Other Cov. Code	Social Security No.	HIC or RR No.
Aid	7 Digit Serial No.	FBU	Pers.		A	B	C	Mo.	Day	Yr.				
85	0123456	0	01	Larrence, Larry				9	14	38	m	Y	512 34 5678	
85	0123456	0	07	Larrence, mary				6	20	39	F	Y	512 98 7654	
83	0123456	0	10	Larrence, Janet				5	14	69	F	Y	522 34 5678	
83	0123456	0	11	Larrence, John			X	7	7	63	m	Y	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I will not accept payment from the Medi-Cal program payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the pa that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the pa This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi- $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By:	Trans.	Replace
Date of Certification					

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th amounts listed above in the "Billed Patient" column.

X SIGNATURE OF APPLICANT DATE

State of California — Health and Welfare Agency

SHARE OF COST DETERMINATION — MFBUs WHICH DO NOT INCLUDE LTC PERSONS

Attachment III-10

Case Name: EXAMPLE 4

County District | County Use

☐ New Application ☐ Redetermination ☒ Change ☒ Retroactive Elig. ☐ Correction

Effective Eligibility Date for this Budget: Mo. Apr - May - Jun Yr. 82

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name — First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverag
								(1) (2)	
								(1) (2)	
								(1) (2)	
19	83	0123456	0	11	John Larrence	7 7 63	M	(1) 521:98:7654... (2)	Y
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. Income of MFBU members applying as ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income deduction	−$20		−$20		−$20	
10. Countable unearned Income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned Income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable Income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month 3
1. Social Security			
2. Net Income from property			
3. Other—Itemize			
4.			
5. Total unearned Income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)			

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month 3
8. Gross earned Income	1100	→	→
9a. If CG in last 4 mos, enter $30			
9b. 1/3 remainder			
10. Mandatory	250		
11. Work Rel	106		
12. Total deduct. (add 9, 10, & 11)	356	→	→
13. Countable earned Income	744	→	→

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Mo
14. Subtotal (add 7 and 13)	744	→	→
15. Child support/ alimony			
16. Total countable Income (14 minus 15)	744	→	→

MC 176M (9/81)

	Month 1	Month 2	Month 3
1. Countable Income from I 18	X		
2. Countable Income from II 16	744	→	→
3. Inc. allocated from LTC/B&C person to family members at home (176W, Part IV)			
4. Combined countable Income (add 1, 2, and 3)	744	→	→
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)			
6. Special deduction (176W, Part II)			
7. Income to determine PA Eligibility			
8. Health Insurance	12.50	→	→
9.			
10.			
11. Total allocations/deductions (add 5 through 10)	12.50	→	→
12. Total net nonexempt Income (4 minus 11)	731.50	→	→
13. Total net nonexempt Income rounded	732	732	732
14. Maintenance need	692	692	692

SHARE OF COST	
13a. Total of Mos 1, 2, and 3	2196
14a. Total of Mos. 1, 2, and 3	2076
15. Share of cost (13a. minus 14a.)	120
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

6/14/82. P/c Mrs. Larrence requested medi-Cal for John and retro eligibility back to march 82. John was previously excluded for ~~ex~~ income.

Eligibility Worker Signature	Worker Number	Computation Date	County Use

EXAMPLE 4

ATTACHMENT III

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Sun

CO DIST	COUNTY U
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below. Month A	Month B	Month C	Share of Cost The amount that you must pay or obligate is:	Page	Re.
Apr 82 (Mo. Yr.)	May 82 (Mo. yr.)	Jun 82 (Mo. Yr.)	$ 30 00		Yes (Yes/N

Name

Address

City/State/Zip

County Code: 49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No.	FBU	Pers.	Name — Last, First	Eligible In: A	B	C	Birthdate: Mo.	Day	Yr.	Sex	Other Cov. Code	Social Security No.	HIC or RR No.
85	0123456	0	01	Larrence, Larry				9	14	38	m	Y	512 34 5678	
85	0123456	0	02	Larrence, Mary				6	20	39	F	Y	512 98 7654	
83	0123456	0	10	Larrence, Janet	X	X	X	5	14	69	F	Y	522 34 5678	
83	0123456	0	11	Larrence, John				7	7	63	m	Y	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare t
payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal progra
that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the p
This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or
third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Date of Mo.	Day	Yr.	Reviewed By:	Trans.	Replace

I have read the instructions on the back of this form. I agree to assume full legal responsibility fo
amounts listed above in the "Billed Patient" column.

X _____ SIGNATURE OF APPLICANT DATE

HARE OF COST DETERMINATION – MFBUs WHICH DO NOT INCLUDE LTC PERSONS Attachment III -13.

Case Name: EXAMPLE 4 | County District | County Use

☐ New Application ☐ Redetermination ☒ Change ☒ Retroactive Elig. ☐ Correction

Effective Eligibility Date for this Budget: Mo. March Yr. 85

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name – First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Covera
								(1) (2)	
								(1) (2)	
								(1) (2)	
9	83	0123456	0	11	John Larrence	7 7 63	M	(1) (2) 521-98-7654	Y
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. Income of MFBU members applying as ABD plus income of spouse or parent (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other–Itemize						
4.						
5. Total (add 1 thru 4)						
6. Deductions						
7. Remainder (5 minus 6)	a.	b.	a.	b.	a.	b.
8. Combined unearned income (add 7a and 7b)						
9. Any income deduction	–$20		–$20		–$20	
10. Countable unearned income (8 minus 9)						

B. NONEXEMPT EARNED INCOME

	Month 1 a. ABD-MN	Month 1 b. Spouse or Parent	Month 2 a. ABD-MN	Month 2 b. Spouse or Parent	Month 3 a. ABD-MN	Month 3 b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. $65 earned Inc. deduction plus $ unused $20						
16. Remainder (14 minus 15)						
17. Countable earned income (divide 16 by 2)						

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month 3
18. Total countable income (add 10 and 17)			

II. Income of MFBU members not listed in I. (except PA or other PA)

A. NONEXEMPT UNEARNED INCOME

	Month 1	Month 2	Month
1. Social Security			
2. Net Income from property			
3. Other–Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)			

B. NONEXEMPT EARNED INCOME

	Month 1	Month 2	Month
8. Gross earned Income			110
9a. If CG in last 4 mos, enter $30			
9b. 1/3 remainder			
10. Mandatory			25
11. Work Rel			10
12. Total deduct. (add 9, 10, & 11)			35
13. Countable earned Income			74

C. TOTAL COUNTABLE INCOME

	Month 1	Month 2	Month
14. Subtotal (add 7 and 13)			74
15. Child support/ alimony			
16. Total countable Income			74

Attachment III 14

	Month 1	Month 2	Month 3
1. Countable income from I 18			
2. Countable income from II 16			744
3. Inc. allocated from LTC/B&C person to family member at home (176W, Part IV)			
4. Combined countable income (add 1, 2, and 3)			744
ALLOCATIONS AND DEDUCTIONS			
5. Allocation to excluded children (176W, Part I)			
6. Special deduction (176W, Part II)			
7. Income to determine PA Eligibility			
8. Health Insurance			12.50
9.			
10.			
11. Total allocations/deductions (add 5 through 10)			
12. Total net nonexempt income (4 minus 11)			731.50
13. Total net nonexempt income rounded	613	613	732
14. Maintenance need	583	583	692

SHARE OF COST	
13a. Total of Mos 1, 2, and 3	1958
14a. Total of Mos. 1, 2, and 3	1854
15. Share of cost (13a. minus 14a.)	104
16. Underpayment adjustment	
17. Adjusted Share of Cost (15 minus 16)	

IV. EXEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

See explanation on prior budget.

Eligibility Worker Signature	Worker Number	Computation Date	County Use

Attachment III

EXAMPLE 4

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Ser

CO DIST	COUNTY U
	Sonoma

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.			Share of Cost	Pap
Month A	Month B	Month C	The amount that you must pay or obligate is:	Retro. E
		Mar 82	$ 10.00	Yes
Mo. Yr.	Mo. yr.	Mo. Yr.		(Yes/N

Name

Address

City/State/Zip

County Code
49

Medical expenses of family members listed below may be used to meet Share of Cost

State Number				Name — Last, First	Eligible In			Birthdate			Sex	Other Cov. Code	Social Security No.	HIC or RR No.
Aid	7 Digit Serial No.	FBU	Pers.		A	B	C	Mo.	Day	Yr.				
85	0123456	0	01	Larrence, Larry				9	14	38	m	N	512 34 5678	
85	0123456	0	02	Larrence, Marry				6	20	39	F	N	512 98 7654	
83	0123456	0	10	Larrence, Janet				5	14	69	F	N	522 34 5678	
83	0123456	0	11	Larrence, John			X	7	7	63	m	N	521 98 7654	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I re
payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal progra
that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the pa
This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi- $
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By:	Trans.	Replace
Date of					

I have read the instructions on the back of this form. I agree to assume full legal responsibility for th amounts listed above in the "Billed Patient" column.

X _____ SIGNATURE OF APPLICANT DATE